100TH CONGRESS
1ST SESSION

H. R. 3766

To provide for certification and require the offering of qualified health plans, to provide Federal assistance to States to establish a program of assistance for low-income persons to purchase comprehensive health insurance and a program for coverage of catastrophic health care expenses, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 15, 1987

Mr. SABO introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To provide for certification and require the offering of qualified health plans, to provide Federal assistance to States to establish a program of assistance for low-income persons to purchase comprehensive health insurance and a program for coverage of catastrophic health care expenses, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

This Act may be cited as the "Comprehensive Health Care Improvement Act of 1987".

TITLE I—QUALIFIED HEALTH INSURANCE PLANS

TITLE I—QUALIFIED HEALTH INSURANCE PLANS

Part A—Definitions and Standards for Qualified Plans

SEC. 101. DEFINITIONS.

For purposes of this title:

(1) The term "Secretary" means the Secretary of Health and Human Services.

(2) The terms "commissioner" and "commissioner of insurance" mean, with respect to a State, the commissioner of insurance of the government of the State or such other State official, designated by the chief executive officer of the State, as may be approved by the Secretary.

(3) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(4)(A) The term "plan of health coverage" means any plan or combination of plans of coverage, including combinations of self-insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health

service plan, or coverage under a health maintenance organization subscriber contract.

(B) The term "qualified plan" means a plan of health coverage which has been reviewed and certified under this part.

(5) The term "health maintenance organization" means an entity that meets the standards for such an organization under section 1301 of the Public Health Service Act.

(6)(A) The term "self-insurance" means a plan of health coverage offered by a self insurer.

(B) The term "self-insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust, or agency, except to the extent of accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges, but does not include an employer which is engaged in the business of providing health care services to the public and which provides health care services directly to its employees at no charge to them.

(C) The term "insurer" means a company offering or selling policies or contracts of accident and health

insurance, but does not include a health maintenance organization.

(D) The term "fraternal beneficiary association" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance.

SEC. 102. STANDARDS FOR QUALIFIED PLANS.

(a) ESTABLISHMENT.—The Secretary shall, in accordance with this part, establish standards for qualified plans and procedures for the review and certification of plans of health coverage as qualified plans.

(b) CERTIFICATION OF "A" QUALIFIED PLANS.—(1) A plan of health coverage shall be certified as an "A" qualified plan if it meets any applicable State requirements with respect to accident and health insurance plans or nonprofit health service plans and meets or exceeds the following minimum standards:

(A) The minimum benefits for a covered individual are, subject to the other provisions of this subsection, equal to at least 80 percent of the covered expenses (described in paragraph (2)) in excess of an annual deductible which does not exceed $250 per person.

(B) The coverage includes a limitation of $3,000 per person on total annual out-of-pocket expenses for covered expenses.

(C) The coverage is subject to no maximum lifetime benefit.

(D) The $3,000 limitation on total annual out-of-pocket expenses (under subparagraph (B)) and the unlimited lifetime benefit (under subparagraph (C)) are not subject to change or substitution by use of an actuarially equivalent benefit.

(2) For purposes of this section, covered expenses are the usual and customary charges for covered services (described in paragraph (3)) when prescribed by a physician or for services described in paragraph (3)(S) when prescribed by a chiropractor, but do not include excluded expenses (described in paragraph (4)).

(3) For purposes of paragraph (2), covered services are the following services and articles:

(A) Hospital services.

(B) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions (other than outpatient mental or dental care) which are rendered by a physician or at a physician's direction.

(C) Drugs requiring a physician's prescription.

(D) Services of a nursing home for not more than 120 days in year if the services would qualify as reimbursable services under title XVIII of the Social Security Act.

(E) Services of a home health agency if the services would qualify as reimbursable services under title XVIII of the Social Security Act.

(F) Use of radium or other radioactive materials.

(G) Oxygen.

(H) Anesthetics.

(I) Prostheses, other than dental.

(J) Rental or purchase, as appropriate, of durable medical equipment, but not including eyeglasses and hearing aids.

(K) Diagnostic X-rays and laboratory tests.

(L) Oral surgery for partially or completely unerupted impacted teeth, for a tooth root without the extraction of the entire tooth, or for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(M) Services of a physical therapist.

(N) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(O) Well baby care.

(P) Physicians' services for routine checkups and annual physicals when prescribed by a physician.

(Q) Multiphasic screening and other diagnostic testing, within such reasonable limits on the reimburse-

ment required for such services as the Secretary shall prescribe.

(R) A second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory, and hospital fees, but the coverage need not include the repetition of any diagnostic tests for such an opinion.

(S) Professional services of a chiropractor.

(4) For purposes of paragraph (2), excluded expenses are the following expenses for services and articles:

(A) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, title XVIII of the Social Security Act, or any other governmental program except as otherwise provided by law.

(B) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(C) Charges for care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under title XVIII of the Social Security Act.

(D) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, except that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge.

(E) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(F) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(5) A health maintenance organization which provides the services required by section 1301 of the Public Health Service Act is deemed to be providing an "A" qualified plan.

(c) CERTIFICATION OF "B" QUALIFIED PLANS.—A plan of health coverage shall be certified as a "B" qualified plan if it meets the minimum standards established by subsection (b), except that the annual deductible (described in subsection (b)(1)(A)) does not exceed $1,000 per person.

(d) CERTIFICATION OF QUALIFIED MEDICARE SUPPLEMENT PLAN.—A plan of health coverage which provides benefits to persons over the age of 65 years shall be certified as a qualified medicare supplement plan if it—

(1) is a plan of insurance protection providing benefits for the costs of medical, surgical, or hospital care and which is designed and marketed to provide benefits which complement or supplement benefits provided under title XVIII of the Social Security Act;

(2) provides coverage—

(A) of 80 percent of the deductibles and copayments required under such title,

(B) of 80 percent of charges for covered services (described in subsection (b)(3)) not paid under such title, and

(C) which is not subject to a maximum lifetime benefit; and

(3) limits to not more than $1,000 per person the total annual out-of-pocket expenses for such covered services.

SEC. 103. DUTIES OF SECRETARY.

(a) CERTIFICATION BY STATES.—The Secretary shall, to the extent feasible, provide for the review and certification, by the Commissioner of each State, of qualified plans to be offered in the State, if he is provided adequate assurances that such review and certification will comply with the requirements of this Act.

(b) GENERAL POLICY.—The Secretary may—

(1) formulate such general policies and promulgate such regulations as will carry out the provisions of this part;

(2) define terms specified in section 102;

(3) appoint advisory committees as necessary to carry out this part;

(4) provide for coordination and consultation with commissioners of insurance and other State officials; and

(5) undertake directly or (for any fiscal year to such extent or in such amounts as are provided in advance in appropriations Acts) through contracts with other entities studies or demonstration programs to develop awareness of the benefits provided under this title.

(c) TIMELY DETERMINATION.—Not later than 90 days after the date an insurer, fraternal beneficiary association, or employer applies to the Secretary for certification of a plan of

health coverage as a qualified plan, the Secretary shall determine whether the plan is a qualified plan and, if so, what type of qualified plan it is.

SEC. 104. USE OF TERM QUALIFIED PLAN AND SALE OF PLANS OF HEALTH COVERAGE.

(a) REGULATION.—The sale of plans of health coverage are in and affect interstate commerce and in order to properly regulate such sales, it is necessary to regulate such sales in intrastate, as well as interstate, commerce.

(b) PROHIBITION OF FALSE LABELING AND ADVERTISING.—No entity may label, advertise, or otherwise describe for purposes of sale a plan of health coverage as—

(1) a qualified plan, unless the plan is a qualified plan under this part and the plan specifies the particular type of qualified plan it is, or

(2) a particular type of qualified plan, unless the plan has been certified under this part as meeting the standards under this part for a plan of that type.

(c) REQUIRED LABELING.—Every plan of health coverage sold or offered for sale shall be labelled as "qualified" or "nonqualified" on the front of the policy or evidence of the insurance. Each advertisement or promotion respecting a plan of health coverage made shall specify whether the plan is "qualified" or "nonqualified".

(d) ENFORCEMENT.—Any entity that violates subsection (b) or (c) shall be treated, for purposes of the Federal Trade Commission Act, as having engaged in an unfair practice.

Part B—Requiring Offering of Certain Qualified Plans

SEC. 111. REQUIRING OFFERING OF PLANS.

(a) REQUIREMENT.—In accordance with regulations which the Secretary shall prescribe, each employer which during a calendar year employed an average number of employees of not less than 10, shall provide or make available to the employees a plan or combination of plans of health coverage which—

(1) has been certified, under part A, as an "A" qualified plan or as a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes such a qualified plan;

(2) is a qualified convertible plan (as defined in subsection (b)); and

(3) provides for the option of coverage, in addition to an employee, of the employee's spouse and dependent children (as defined in subsection (f)(2)).

(b) QUALIFIED CONVERTIBLE PLAN DEFINED.—In this section, the term "qualified convertible plan" means a plan of health coverage—

(1) which includes the right of each individual enrolled in the plan to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group;

(2) under which the individual may exercise his right to conversion within 30 days after the date of leaving the group or within 30 days following the date he receives notice of cancellation or termination of coverage of the group and upon payment of premiums from the date of termination or cancellation;

(3) under which due notice of cancellation or termination of coverage for a group is provided to each individual having coverage in the group by the insurer, self-insurer, or health maintenance organization canceling or terminating the coverage, except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group;

(4) under which the employer agrees to provide the insurer or health maintenance organization, upon request, with a list of the names and addresses of covered individuals; and

(5) which provides that, in the case of the death of the individual in whose name the contract was issued, every other individual then covered under the contract may elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived.

(c) ENFORCEMENT.—(1) Any employer which knowingly does not comply with the requirements of subsection (a) shall be subject to civil penalty of not more than $10,000. If such noncompliance continues, a civil penalty may be assessed and collected under this subsection for each 30-day period such noncompliance continues. Such penalty may be assessed by the Secretary and collected in a civil action brought by the Attorney General in a United States district court.

(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the em-

ployer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

(3) In any civil action brought to review the assessment of a civil penalty assessed under this subsection, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty, and in any civil action to collect such a civil penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty unless in a prior civil action to review the assessment of such penalty the court held a trial de novo on such assessment.

(d) ENFORCEMENT.—Any employee whose employer has allegedly violated subsection (a) may bring an action in an appropriate court in a State or the United States to enjoin such violation.

(e) SPECIAL RULES.—(1) No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective-bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees.

(2) An individual conversion contract under a qualified convertible plan issued by a health maintenance organization shall not be treated as an individual enrollment contract with a health maintenance organization with respect to any limita-

tion provided in any law respecting open enrollment periods of such organizations.

(f) DEFINITIONS.—For purposes of this section:

(1) The term "employee" does not include an employee excluded from consideration under section 89 of the Internal Revenue Code of 1986 under subsection (h) of that section.

(2) The term "dependent child" means, with respect to an individual, the individual's (A) unmarried child under the age of 19, (B) child under the age of 25 who is a student and who is financially dependent upon the individual, and (C) child of any age who is disabled and financially dependent upon the individual.

(3) The term "health benefits" means benefits, offered to employees on an indemnity or prepaid basis, which pay the costs of or provide medical, surgical, or hospital care.

SEC. 112. EFFECTIVE DATE OF PART.

This part shall apply to employment on or after January 1, 1989.

Part C—Offering of Comprehensive Health Insurance and Qualified Medicare Supplement Plans by States

SEC. 121. DEFINITIONS.

For purposes of this part:

(1) The term "association" means, with respect to a State, the comprehensive health association established by the State pursuant to this part.

(2) The term "writing carrier" means, with respect to a State, the insurer or insurers and health maintenance organization or organizations in the State selected by the association of the State and approved by the commissioner of insurance of the State to administer the comprehensive health insurance plan.

(3) The term "comprehensive health insurance plan" means policies of insurance and contracts of health maintenance organization coverage offered by an association through the writing carrier in the State.

(4) The term "health policy" means an insurance or nonprofit health service plan contract providing benefits for hospital, surgical, and medical care, but does not include coverage which is—

(A) limited to disability or income protection coverage,

(B) automobile medical payment coverage,

(C) supplemental to liability insurance,

(D) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis,

(E) insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled (as defined in the policy),

(F) designed solely to provide dental or vision care,

(G) accident and health insurance issued—

(i) to a common carrier covering a group of persons who may become passengers on the common carrier,

(ii) to an employer covering the employer's employees who are exposed to exceptional hazards incident to their employment,

(iii) to an educational institution (or head thereof) covering its students or teachers,

(iv) to a volunteer group, covering members of the group,

(v) to a sports team or camp covering members of the team or campers, or

(vi) any other substantially similar group (as determined by the Secretary); or

(H) accident-only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services,

except that the provisions of subparagraph (D) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

SEC. 122. REQUIRING OFFERING AS A CONDITION FOR STATE RECEIPT OF MEDICAID FUNDS.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking out "and" at the end of paragraph (48);

(2) by striking out the period at the end of paragraph (49) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (49) the following new paragraph:

"(50) provide (in the case of each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico) for the establishment and operation of a comprehensive health association in the State and for a comprehensive health insurance plan in

the State, in accordance with part C of title I of the Comprehensive Health Care Improvement Act of 1987.".

(b) EFFECTIVE DATE.—(1) The amendments made by subsection (a) shall (except as otherwise provided in paragraph (2)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after October 1, 1989.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a)(3), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

SEC. 123. DUTIES OF COMMISSIONERS OF INSURANCE.

Each State commissioner of insurance, consistent with any regulations the Secretary may promulgate to carry out this part—

(1) may formulate general policies to advance the purposes of this title;

(2) shall supervise the creation of the comprehensive health association in the State (within the limits described in section 124);

(3) shall approve the selection of the writing carrier by the association in the State and approve the association's contract with the writing carrier, including the State plan coverage and premiums to be charged;

(4) may appoint advisory committees with respect to implementation of this part;

(5) shall conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association in the State;

(6) shall contract with the Federal Government and may contract with any other unit of government to ensure coordination of the State plan of the association with other governmental assistance programs;

(7) may undertake, directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits provided under this Act, so that residents of the State may best avail themselves of the health care benefits provided hereunder;

(8) may contract with insurers and others for administrative services; and

(9) may adopt, amend, suspend, and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of this part.

SEC. 125. ESTABLISHMENT OF COMPREHENSIVE HEALTH ASSOCIATIONS IN STATES.

(a) REQUIREMENT.—Each State must provide for the establishment of a comprehensive health association with membership consisting of all insurers, self-insurers, fraternals beneficiary associations, other entities (such as Blue Cross/Blue Shield plans) offering health policies, and health maintenance organizations licensed or authorized to do business in the State. Each association must be exempt from taxation under the laws of the State and all property owned by the association must be exempt from State taxation.

(b) BOARD OF DIRECTORS.—The board of directors of each association for a State shall be made up of seven individuals selected by participating members, subject to the approval of the commissioner of insurance of the State. To select the initial board of directors, and to initially organize each association, each commissioner shall give notice to all its members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premi-

um, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the State in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the money of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) MEMBERSHIP.—All members of an association shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in the State. Each association in a State shall submit bylaws and operating rules to the commissioner for that State for approval.

(d) REINSURANCE CONTRACTS.—All members shall enter into a reinsurance contract with the association according to terms specified in section 125(d). For members operating on the date of the enactment of this Act, the first such contract of reinsurance shall be executed on or before Octo-

ber 1, 1989, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the State shall remain liable under the contract for the reinsurance contracted for during that calendar year.

(e) EXEMPTION FROM ANTITRUST LAWS.—In the performance of their duties as members of an association, the members shall be exempt from the application of Federal and State antitrust laws.

(f) AUTHORITY.—(1) Each association shall have the authority, under State law—

(A) to exercise the powers granted to insurers under the laws of the State;

(B) to sue or be sued;

(C) to enter into contracts with insurers, similar associations in other States, or with other persons for the performance of administrative functions (including the functions provided for in paragraphs (2) and (3)); and

(D) establish administrative and accounting procedures for the operation of the association.

(2) Each association may provide for the reinsuring of risks incurred as a result of issuing qualified plans by members of the association. Each member which elects to reinsure its risks shall determine the categories of coverage it elects to reinsure in the association. These categories are—

(A) individual qualified plans, excluding group conversions,

(B) group conversions,

(C) group qualified plans with fewer than 50 employees or members, and

(D) major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure their risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every health policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred, in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner of the State before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures to be established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110

percent of the total anticipated expenses incurred by the association for the reinsurance.

(3) The association may provide for the administration by the association of policies which are reinsured pursuant to paragraph (2). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every health policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

SEC. 125. MINIMUM BENEFITS AND OPERATION OF COMPREHENSIVE HEALTH INSURANCE PLANS.

(a) REQUIRED POLICIES—Each association through its comprehensive health insurance plan shall offer policies which provide the benefits of an "A" and "B" qualified plans and of a qualified medicare supplement plan. It shall offer health maintenance organization contracts in those areas of the State where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

(b) ENTITLEMENT TO ENROLL.—(1) Upon the certification, by an association in a State, of an individual under sec-

tion 127(a), the individual is entitled to enroll in the comprehensive health insurance plan in the State by payment of the State plan premium to the writing carrier.

(2) For the first 18 months of operation of each comprehensive health insurance plan in a State, the association for the State shall establish the following premiums (hereinafter in this part referred to as "State plan premiums") to be charged for membership in the comprehensive health insurance plan:

(A) The premium for the "A" qualified plan and for the "B" qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in an "A" individual qualified plan of insurance or in a "B" individual qualified plan of insurance, respectively, in force in the State.

(B) The premium for a qualified medicare supplement plan shall be the average of rates charges by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan in the State.

(C) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

For subsequent enrollees or renewals of membership, the schedule of premiums for membership in the comprehensive

health insurance plan shall be designed by each association to be self-supporting and based on generally accepted actuarial principles.

(3) Any employer which has in its employ one or more individuals enrolled in the comprehensive health insurance plan may make all or any portion of the State plan premium payment to the State plan directly to the writing carrier.

(c) LIMIT ON REFERRAL FEES.—Not less than 87½ percent of the State plan premiums paid to the writing carrier in any State may be used to pay claims, and not more than 12½ percent of such premiums may be used for the payment of agent referral fees (as authorized by section 128(c)) and for the payment of the writing carrier's direct and indirect expenses (as specified in section 126(g)).

(d) USE OF SURPLUS.—Any income in excess of the costs incurred by an association in providing reinsurance or administrative services pursuant to paragraphs (2) and (3) of section 124(f) shall be held at interest and used by the association to offset losses due to claims expenses of the State plan or allocated to reduce State plan premiums.

(e) SHARING LOSSES.—(1) Each member of an association shall share the losses due to claims expenses of the comprehensive health insurance plan's health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses in-

curred or estimated to be incurred by the association incident to the conduct of its affairs, pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 124(d). Deviations in the claim experience of the State plan from the premium payments allocated to the payment of benefits shall be the liability of association members. Association members shall share in the claims expense of the State plan and operating and adminstrative expenses of the association in an amount equal to the ratio of the member's total cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of residents of the State as divided into the total cost of self-insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of residents of the State, as determined by the commissioner of the State. The reinsurance contract shall provide for an annual determination and assessment of each member's liability, if any. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. Subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments as may be necessary to assure the financial capability of the association in meeting

the incurred or estimated claims expenses of the State plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of the date of notification by the association shall be grounds for termination of the member's membership.

(2) Net gains, if any, from the operation of a State plan by an association shall be held at interest and used by the association to offset future losses due to claims expenses of the State plan or allocated to reduce State plan premiums.

SEC. 126. ADMINISTRATION OF PLANS.

(a) SUBMISSION OF POLICIES.—Any member of an association in a State may submit to the commissioner for the State the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

(b) SELECTION.—Upon the approval, under State law, of the commissioner for a State of health policy forms and contracts submitted pursuant to State law by members of the association for the State, the association may select such policies and contract to be the comprehensive health insurance plan. This selection shall be based upon criteria includ-

ing the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. Each association may select separate writing carriers for the four types of qualified plans (including the qualified medicare supplement plan) and the health maintenance organization contract.

(c) ADMINISTRATIVE AND CLAIMS FUNCTIONS.—Each writing carrier shall perform all administrative and claims payment functions required by this section. Each writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the commissioner for the State. The commissioner shall approve or deny such a request to terminate within 90 days of the date of its receipt of the request. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months before the date of the expiration of each three-year period, the association shall invite submissions of health policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subsection (b) in selecting a writing carrier for the subsequent three-year period.

(d) POLICY OF INSURANCE.—Each writing carrier shall provide to all eligible persons enrolled in the comprehensive health insurance plan an individual health policy or certifi-

cate, setting forth a statement as to the insurance protection to which the individual is entitled, with whom claims are to be filed, and to whom benefits are payable. The health policy or certificate shall indicate that coverage was obtained through the association.

(e) REPORT ON OPERATIONS.—Each writing carrier in a State shall submit to the association and commissioner in the State on a monthly basis a report on the operation of the State comprehensive health insurance plan.

(f) PAYMENT OF CLAIMS.—All claims shall be paid by the writing carrier pursuant to the provisions of this part and shall indicate that the claim was paid by the State comprehensive health insurance plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(g) PAYMENT BY PLAN.—Each writing carrier shall be reimbursed from the State plan premiums received for its direct and indirect expenses. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the State comprehensive health insurance plan, but shall not include costs directly related to the original submission of health policy forms before selection as the writing carrier. Each as-

sociation shall approve cost accounting methods to substantiate its writing carrier's cost reports consistent with generally accepted accounting principles.

(h) AGENCY.—Each writing carrier shall at all times when carrying out its duties under this section be considered an agent of the association and the commissioner of insurance with civil liability, subject to any State law provisions respecting limitation on the time period for the filing of actions against a State agency.

(i) TAX EXEMPTION OF PREMIUMS.—Premiums received by a writing carrier for the comprehensive health insurance plan are specifically exempted from any taxation under State law based on receipt of premiums.

SEC. 127. ENROLLMENT.

(a) OPEN ENROLLMENT.—The comprehensive health insurance plan for a State shall be open for enrollment by individuals residing in the State. Such an individual may enroll by submitting a certificate of eligibility to the writing carrier, which certificate may provide the following:

(1) Name, address, age, and length of time at residence of the applicant.

(2) Name, address, and age of any dependents (if any), if they are to be insured.

(3) A designation of the coverage desired.

Such an individual may not purchase more than one health policy from a State comprehensive health insurance plan.

(b) REVIEW OF APPLICATION.—Within 30 days of the date of receipt of a certificate described in subsection (a), the writing carrier shall either reject the application for failing to comply with the requirements in that subsection or forward to the individual a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's State plan premium, and shall be retroactive to the date of the application, if the applicant otherwise complies with the requirements of this part.

SEC. 128. SOLICITATION.

(a) DISSEMINATING INFORMATION.—Each association in a State, pursuant to a plan approved by the commissioner for the State, shall disseminate appropriate information to the residents of the State regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of dissemination may include use of the press, radio, and television, as well as publication in appropriate State offices and publications.

(b) PUBLIC PARTICIPATION.—Each association shall devise and implement means of maintaining public awareness of the provisions of this title and shall administer this part in a manner which facilitates public participation in the State plan.

(c) AGENT'S REFERRAL FEES.—Each writing carrier shall pay an agent's referral fee, in an amount to be determined by the association, to each insurance agent who refers an applicant to the State comprehensive health insurance plan, if the application is accepted. Selling or marketing of qualified State comprehensive health insurance plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money it receives as premiums for the plan.

(d) NOTICE.—The State shall provide that each insurer in the State which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the State comprehensive health insurance plan, the requirements for being accepted in it, and the procedure for applying to it.

TITLE II—PROGRAM OF ASSISTANCE TO STATES FOR ASSISTING LOW-INCOME INDIVIDUALS TO PURCHASE COMPREHENSIVE HEALTH INSURANCE

SEC. 201. SHORT TITLE; EFFECTIVE DATE.

(a) SHORT TITLE.—This title may be cited as the "Comprehensive Health Insurance Assistance Act of 1987".

(b) EFFECTIVE DATE—The amendment made by section 202 shall apply to payments made, under a State plan

approved under title XXI of the Social Security Act, on and after October 1, 1988.

SEC. 202. AMENDMENT TO SOCIAL SECURITY ACT.

The Social Security Act is amended by adding after title XX the following new title:

"TITLE XXI—GRANTS TO STATES FOR ASSISTANCE TO LOW-INCOME INDIVIDUALS IN THE PURCHASE OF COMPREHENSIVE HEALTH INSURANCE

"APPROPRIATION

"SEC. 2101. For the purpose of enabling each State, as far as practicable under the conditions in such State, to provide assistance to low-income individuals in the purchase of comprehensive health insurance under this title, there is hereby authorized to be appropriated for each fiscal year $1,830,000,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for comprehensive health insurance assistance to low-income individuals.

"STATE PLANS FOR COMPREHENSIVE HEALTH INSURANCE ASSISTANCE TO LOW-INCOME INDIVIDUALS

"SEC. 2102. (a) In order to be approved by the Secretary under this title, a State plan for comprehensive health

insurance assistance to low-income individuals must meet the following requirements:

"Statewide Scope and State Financial Participation

"(1) The plan must provide—

"(A) that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them, and

"(B) for financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan with respect to which payments under section 2103 are authorized by this title, and provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the assistance available under the plan.

"Administration of Plan

"(2) The plan must provide—

"(A) for designation of an appropriate State agency (hereinafter in this title referred to as 'the State agency') to administer the plan;

"(B) such safeguards as may be necessary to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan; and

"(C) that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.

"Provision of, and Applications for, Assistance

"(3) The plan must provide—

"(A) for making partial or full assistance available to low-income individuals, as determined by the State, for such individuals to purchase 'A' qualified plans or qualified medicare supplement plans (as certified under title I of the Comprehensive Health Care Improvement Act of 1987);

"(B) reasonable standards for determining eligibility for and the extent of assistance under the plan which are consistent with the objectives of this title and provide for reasonable evaluation of income and resources;

"(C) that any individual wishing to make application for assistance under the plan shall have opportunity to do so and that such assistance shall be furnished with reasonable promptness to all eligible individuals; and

"(D) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness.

"(b) The Secretary shall approve any plan which fulfills the requirements specified in subsection (a), except that he shall not approve any plan which imposes as a condition for eligibility for assistance under the plan any citizenship requirement which excludes any citizen of the United States.

"PAYMENTS TO STATES

"SEC. 2103. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1988, subject to subsection (b), an amount equal to 50 percent of so much of the sums expended during such quarter as are attributable either to assistance under the plan to low-income individuals or to expenses found necessary by the Secretary for the proper and efficient administration of the plan.

"(b) The amount of funds which the Secretary is otherwise obligated to pay a State under subsection (a) during a quarter may not exceed the product of $1.88 and the population of the State.

"(c)(1) Before the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under this section for the quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of this section, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

"(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an

overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan.

"(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

"(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"OPERATION OF STATE PLANS

"SEC. 2104. If the Secretary, after reasonable notice and opportunity for hearing to the State, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 2102; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify the State that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satis-

fied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"PENALTIES

"SEC. 2105. Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any assistance under a State plan approved under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such assistance,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such assistance, or (B) the initial or continued right to any such assistance of any other individual in whose behalf he has applied for or is receiving such assistance, conceals or fails to disclose such event with an intent fraudulently to secure such assistance either in a greater amount or quantity than is due or when no such assistance is authorized, or

"(4) having made application to receive any such assistance for the use and benefit of another and

having received it, knowingly and willfully converts such assistance or any part thereof to a use other than for the use and benefit of such other person,

shall (A) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the sale, or offering for sale (by that person), of qualified plans for which assistance is or may be made under this title, be fined not more than $25,000 or imprisoned for not more than five years, or both, or (B) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this section, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.''.

SEC. 203. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by redesignating section 1922 as section 1923 and by inserting after section 1922 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

"SEC. 1923. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community

spouse, after the institutionalized spouse has been determined to be eligible for medical assistance, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if pay-

ment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to ½ of such total value.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment,

require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources held in the name of (or for the sole benefit of) the community spouse shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (f)(2)(A) (as of the time of application for benefits) or, if greater, the amount that a court has ordered to be retained by the community spouse for the support of the community spouse.

"(3) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(4) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance which is reasonable in amount for clothing and other personal needs of the individual while in an institution, in an amount not less than $35 for an institutionalized individual and $70 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party.

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or commu-

nity spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Rec-

onciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (4)); plus

"(iii) ½ of the amount by which the income available to the institutionalized spouse exceeds the sum of the amounts described in clauses (i) and (ii).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)), or, if greater, the amount specified under the State plan.

"(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(5) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) NOTICE AND FAIR HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(A) the community spouse monthly income allowance because the amount of the minimum monthly maintenance needs allowance (established

under subsection (d)(3)) is not adequate to support the community spouse without financial duress;

"(B) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(C) the computation of the spousal share of resources under subsection (d)(1)(B);

"(D) the attribution of resources under subsection (d)(2); or

"(E) the determination of the community spouse resource allowance (as defined in subsection (f)(2)), such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. If either such spouse establishes that the minimum monthly maintenance needs allowance or the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is not adequate to support the community spouse without financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A) (or for the community spouse resource allowance under subsection (f)(2)), an amount adequate to support the community spouse without financial duress.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (f)), or, if greater, the amount specified under the State plan (but not more than 4 times the amount described in clause (i));

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) 4 times the amount described in clause (i);

"(iii) the amount established under subsection (e)(2); or

"(iv) the amount transferred under a court order under paragraph (3),

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(B) and (f)(2)(A)(i) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a hospital, skilled nursing facility, or intermediate care facility, or who (at the option

of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a hospital, skilled nursing facility, or intermediate care facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(49)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 24-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to (A) the total uncompensated value of the resources so transferred, divided by (B) the average cost, to a private patient at the time of the appli-

cation, of nursing home care in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to the individual's spouse or child who is under age 21, or (with respect to State eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1923(h)(2), or the individual's child who is blind or permanently and totally disabled;

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; and

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who—

"(A) is an inpatient in a hospital, skilled nursing facility, or intermediate care facility, and

"(B) is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(4) A State may not provide for any period of ineligibility for an institutionalized individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) CONFORMING AMENDMENT.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 122(a) of this Act, is amended—

(1) in paragraph (10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of paragraph (49);

(3) by striking out the period at the end of paragraph (50) and inserting "; and", and

(4) by inserting after paragraph (50) the following new paragraph:

"(51)(A) meet the requirements of section 1923 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets)."; and

(5) by adding at the end the following new sentence: "For purposes of paragraph (10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(d) STUDY OF MEANS OF RECOVERING COSTS OF NURSING FACILITY SERVICES FROM ESTATES OF BENEFICIARIES.—The Secretary of Health and Human Services shall study the means for recovering amounts from estates of deceased medicaid beneficiaries (or the estates of the spouses of such deceased beneficiaries) to pay for the medical assistance for skilled nursing facility or intermediate care facility services furnished, under title XIX of the Social Security Act, to such medicaid beneficiaries. The Secretary shall report to Congress, not later than December 31, 1989, on such means, and include appropriate recommendations for changes in legislation.

(e) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraphs (2) and (3)) to payments under title XIX of the Social Security

Act for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3)(A) The amendments made by paragraphs (1) and (6) of subsection (c) shall apply to medical assistance furnished on or after October 1, 1982.

(B) Section 1923 of the Social Security Act (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after January 1, 1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of Janu-

ary 1, 1989, to individuals institutionalized on or after such date.

(C) The amendments made by subsection (b) shall apply, as of January 1, 1989, to individuals who apply for, or are eligible for, medical assistance on or after such date, without regard to when resources were transferred.

TITLE III—PROGRAM OF ASSISTANCE TO STATES FOR ASSISTING INDIVIDUALS WHO INCUR CATASTROPHIC EXPENSES FOR HEALTH CARE

SEC. 301. SHORT TITLE; EFFECTIVE DATE.

(a) SHORT TITLE.—This title may be cited as the "Catastrophic Health Care Expenses Assistance Act of 1987".

(b) EFFECTIVE DATE.—The amendment made by section 302 shall apply to payments made, under a State plan approved under title XXII of the Social Security Act, on and after October 1, 1989.

SEC. 302. AMENDMENT TO SOCIAL SECURITY ACT.

The Social Security Act is amended by adding after title XXI, as added by section 201 of this Act, the following new title:

"TITLE XXII—GRANTS TO STATES FOR ASSISTANCE TO INDIVIDUALS INCURRING CATASTROPHIC EXPENSES FOR HEALTH CARE

"APPROPRIATION

"SEC. 2201. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance for catastrophic illness under this title, there is hereby authorized to be appropriated for each fiscal year $575,000,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance for catastrophic illness.

"STATE PLANS FOR MEDICAL ASSISTANCE FOR CATASTROPHIC ILLNESS

"SEC. 2202. (a) To be approved by the Secretary under this title, a State plan for medical assistance for catastrophic illness must meet the following requirements:

"Statewide Scope and State Financial Participation

"(1) The plan must provide—

"(A) that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them, and

"(B) for financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan with

respect to which payments under section 2203 are authorized by this title, and provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the assistance available under the plan.

"Administration of Plan

"(2) The plan must provide—

"(A) for designation of an appropriate State agency (hereinafter in this title referred to as 'the State agency') to administer the plan;

"(B) such safeguards as may be necessary to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan; and

"(C) that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to

assure the correctness and verification of such reports.

"Provision of, and Applications for, Assistance

"(3) Subject to paragraph (4), the plan must provide for paying—

"(A) at least 90 percent of all qualified expenses of an eligible individual and the individual's dependents in excess of the greater of—

"(i) the sum of 30 percent of his household income under $25,000, plus 40 percent of his household income between $25,000 and $40,000, plus 50 percent of his household income in excess of $40,000 (or such lower respective percentages of such incomes, or of such higher incomes, as the State may establish), or

"(ii) $3,000 (or such lower amount as the State may establish)

for the 12-consecutive-month period in which the applicant becomes an eligible person; and

"(B) 100 percent of all qualified nursing home expenses of an eligible individual and the individual's dependents in excess of 20 percent (or such lower percentage as the State may establish) of his household income.

The plan may not provide for charging any premiums, copayments, or deductibles, except as provided in the previous sentence.

"Excess Charges and Utilization Review

"(4)(A) A plan must provide such methods and procedures relating to the utilization of, and the payment for, services for which assistance is available under the plan as may be necessary to safeguard against unnecessary utilization of such services and to assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.

"(B) A plan may provide that if the State agency determines that—

"(i) the charge for a service is excessive and not reasonable, payment may be limited under the plan to the reasonable charge for the service, or

"(ii) a health service provided to an individual was not medically necessary, the plan is not obligated to pay for the service.

In making either or both of the determinations described in clauses (i) and (ii), a State agency may contract with utilization and quality control and peer review organizations (with a contract under part B of title XI).

"Applications for Assistance

"(5) The plan must provide—

"(A) reasonable standards for determining eligibility for and the extent of assistance under the plan which are consistent with the objectives of this title and provide for reasonable evaluation of income and resources;

"(B) that (i) any individual wishing to make application for assistance under the plan shall have opportunity to do so, (ii) each such application shall include a listing of expenses incurred (before the date of the application) for health services and shall designate the date on which the 12-consecutive-month period (described in section 2205(1)) began, and (iii) that such assistance shall be furnished with reasonable promptness to all eligible individuals; and

"(C) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness.

"Payor of Last Resort and Collection of Other Insurance

"(6) The plan must provide that—

"(A) the State agency will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability,

"(B) where the State agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the assistance is made available under this title, and

"(C) in any case where such a legal liability is found to exist after assistance has been made available on behalf of an eligible individual, the State agency will seek reimbursement for such assistance to the extent of such legal liability.

"Prohibition of Payment to Factors

"(7) The plan must provide that no assistance under the plan for any service provided to an individual shall be made to anyone other than such individual or the person or institution providing such service, under an assignment or power of attorney or otherwise; except that—

"(A) in the case of any service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of

such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such service; and

"(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the

amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

"(b) The Secretary shall approve any plan which fulfills the requirements specified in subsection (a), except that he shall not approve any plan which imposes as a condition for eligibility for assistance under the plan any citizenship requirement which excludes any citizen of the United States.

"PAYMENTS TO STATES

"SEC. 2203. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1988, subject to subsections (b) and (c), an amount equal to 50 percent of so much of the sums expended during such quarter as are attributable either to payments made to eligible individuals under the plan or to expenses found necessary by the Secretary for the proper and efficient administration of the plan.

"(b) The amount of funds which the Secretary is otherwise obligated to pay a State under subsection (a) during a quarter may not exceed the product of $0.625 and the population of the State.

"(c) No payment may be made under this title to a State with respect to expenses for which obligations have been

made to the extent that, in accordance with regulations established by the Secretary—

"(1)(A) the charges on which the expenses are based are not reasonable, or

"(B) if the expenses were for inpatient hospital services, the amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

"(2) the expenses were for health services which were not medically necessary; or

"(3) expenses were for services provided by a provider or other person during any period of time during which payment may not be made under title XVIII with respect to services furnished by that provider or person solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary

under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or

"(4) if the expenses were for services provided by a hospital or skilled nursing facility, such hospital or skilled nursing facility does not have in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title to such hospital or facility, except that the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k); or

"(5) a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided assistance under the plan.

"(d)(1) Before the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under this section for the quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of this section, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

"(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan.

"(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

"(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"OPERATION OF STATE PLANS

"SEC. 2204. If the Secretary, after reasonable notice and opportunity for hearing to the State, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 2202; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify the State that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"DEFINITIONS

"SEC. 2205. For purposes of this title:

"(1) The term 'eligible individual' means, with respect to a State, any individual who is a resident of the State and who, while residing in the State, incurs an obligation to pay qualified expenses for himself and any dependents in any 12-consecutive-month period exceeding the greater of—

"(A) 30 percent of his household income up to $25,000, plus 40 percent of his household income between $25,000 and $40,000, plus 50 percent of his household income in excess of $40,000 (or such lower respective percentages of such incomes, or of such higher incomes, as the State may establish), or

"(B) $3,000 (or such lower amount as the State may establish).

"(2) The term 'qualified expense' means any charge incurred after October 1, 1988, for a health service—

"(A) which is a covered expense under section 102(b)(2) of the Comprehensive Health Care Improvement Act of 1987, and

"(B) for which no third party is liable.

"(3) The term 'dependents' means, with respect to an individual—

"(A) the individual's spouse; and

"(B) any of the individual's (i) unmarried children under the age of 19 years, (ii) children under the age of 25 who are students and financially dependent upon the individual, or (iii) children of any age who are disabled and financially dependent upon the individual.

"(4) The term 'household income' means, with respect to an individual, the sum of items specified in subparagraph (A), less the items specified in subparagraph (B), of the individual and all his dependents 23 years of age or older for the calendar year preceding the year in which the individual's application is filed under this title:

"(A) Items included in income:

"(i) Gross income (as defined in section 61(a) of the Internal Revenue Code of 1986).

"(ii) Any pension or annuity (including railroad retirement benefits, all payments received under this Act, supplemental security income, and veterans disability pensions) which was not exclusively funded by the individual or spouse, or which was funded ex-

clusively by the individual or spouse and which funding payments were excluded from gross income (for purposes of the Internal Revenue Code of 1986) in the years when the payments were made.

"(iii) Nontaxable interest received from the State or Federal Government or any instrumentality or political subdivision thereof.

"(iv) Worker's compensation.

"(v) Unemployment benefits.

"(vi) Nontaxable strike benefits.

"(vii) Gross amounts of payments received in the nature of disability income or sick pay as a result of accident, sickness, or other disability, whether funded through insurance or otherwise.

"(B) Items not included in income:

"(i) Amounts excluded from income under sections 101(a), 102, 117, 121, 127, and 129 of the Internal Revenue Code of 1986.

"(ii) The amount of any pension or annuity which was exclusively funded by the individual or spouse and which funding payments were not excluded from adjusted gross

income (for purposes of the Internal Revenue Code of 1986) in the years when the payments were made.

"(iii) Gifts from nongovernmental sources.

"(iv) Surplus food or other relief in kind supplied by a government agency.

"(6) The term 'third party' means any person other than the eligible individual or his dependents.

"PENALTIES

"SEC. 2206. (a) Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any assistance under a State plan approved under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such assistance,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such assistance, or (B) the initial or continued right to any such assistance of any other individual in whose behalf he has applied for or is receiving such assistance, conceals or fails to disclose such event with an

intent fraudulently to secure such assistance either in a greater amount or quantity than is due or when no such assistance is authorized, or

"(4) having made application to receive any such assistance for the use and benefit of another and having received it, knowingly and willfully converts such assistance or any part thereof to a use other than for the use and benefit of such other person,

shall (A) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of services for which assistance is or may be provided under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (B) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this section, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate;

but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

"(b)(1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

"(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

"(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

"(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

"(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title;

"(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services; and

"(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under this title if—

"(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

"(ii) in the case of an entity that is a provider of services, the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity.".

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